INFORMATIONAL LETTER NO.1731-MC-FFS-D

DATE: November 4, 2016

TO: All Iowa Medicaid Providers

APPLIES TO: Managed Care, Fee-for-Service, Dental

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Affordable Care Act Section 1557 Operational Requirements

EFFECTIVE: Immediately

New guidance has been issued by the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR) on Affordable Care Act (ACA) Section 1557.

ACA Section 1557 prohibits discrimination based on race, color, national origin, sex, age or disability in health programs and activities that receive Federal funds. Section 1557 assists populations that have been most vulnerable to discrimination in health care and health coverage, including: women, members of the lesbian, gay, bisexual and transgender (LGBT) community, individuals with disabilities and individuals with limited English proficiency (LEP).

Section 1557 builds on long-standing Federal civil rights laws

- Title VI of the Civil Rights Act of 1964
- Title IX of the Education Amendments of 1972
- Section 504 of the Rehabilitation Act of 1973
- Age Discrimination Act of 1975

OCR's final regulation implementing Section 1557 was published in the Federal Register on May 18, 2016 (Nondiscrimination in Health Programs and Activities, Final Rule (81 FR 31376)). The final regulations can be found at 45 CFR Part 92.

Section 1557 requirements directly impact communications and operations. This informational letter provides guidance on the operational requirements of Section 1557 related to sex discrimination, language services and disability requirements. An additional informational letter addresses the communications requirements of Section 1557.

To ensure compliance, the IME is providing Section 1557 operational guidance below. It is the responsibility of the provider/covered entity to ensure appropriate policies and practices are in place to prohibit discrimination based on sex or disability as described in Section 1557.

Sex Discrimination:
Sex discrimination prohibited under Section 1557 includes discrimination based on:

- **An individual's sex**- Includes but is not limited to, discrimination on the basis of sex stereotyping and gender identity.
- **Pregnancy, childbirth and related medical conditions**
- **Gender identity**- Means an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and may be different from one's sex assigned at birth.
- **Sex stereotyping**- Includes expectations that individuals will act in conformity with gender expressions associated with being male or female, such as appropriate roles of a certain sex.

<u>Under Section 1557, covered entities must:</u>

- Provide equal access to health care and insurance coverage regardless of an individual's sex, including gender identity and sex stereotypes.
- Treat individuals consistent with their gender identity, including with respect to access to facilities.

<u>But cannot:</u>

- Deny or limit sex-specific health services based solely on the fact that the gender recorded for the individual does not align with the sex that usually receives those types of sex-specific services.

<u>Sex Discrimination Requirements for Covered Entities:</u>

- Record coding that flags a gender mismatch for certain sex-specific services, by itself, is not prohibited if it does not result in a delay or denial of services.
- Requiring transgender individuals to repeatedly go through an appeals process to correct gender coding issues in order to obtain coverage for certain services may be discriminatory.
- Covered entities should utilize interim methods to correct gender coding mismatch issues.
- Covered entities are free to develop methods for processing claims for sex-specific services by transgender individuals as long as process is not overly burdensome and provides timely access to care.
- Bright line test: Categorical exclusions for all health care services related to gender transition are per se discriminatory.
- Denial for specific health services related to gender transition will be evaluated based on the application of longstanding nondiscrimination principles to the facts of the particular plan.
- The regulation does not affirmatively require issuers to cover any particular procedure or treatment for gender transition-related care.
- Issuers must have neutral standards and administer them in a nondiscriminatory manner.
- The regulation does not restrict an issuer from determining whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case.
- Sex-specific programs and activities are permitted only if the covered entity can demonstrate an exceedingly persuasive justification, that is, that the program is

substantially related to achievement of an important health-related or scientific objective.
- Justification that relies on generalizations or stereotypes would not be sufficient.

Language Services
- Development and implementation of a language access plan is encouraged.
    - Plans help covered entities, including State Medicaid agencies, to be prepared to take reasonable steps to provide meaningful access to each individual with LEP who may require assistance.
    - A plan is one factor, among other relevant factors, that OCR will consider in determining compliance.
- Individuals providing oral language assistance or written translation must be qualified.
    - Includes bilingual/multilingual staff
    - Oral interpreters
    - Translators
    - Regulation codifies restrictions on the use of family members, friends, and children to interpret or facilitate communication.
    - If video remote interpreting is used, the services must meet certain quality standards.

Disability Requirements:
- Covered entities must make reasonable changes to policies, practices and procedures where necessary to provide equal access for individuals with disabilities.
- Covered entities must ensure effective communication with persons with disabilities
- Requires entities to give “primary consideration” to individual’s choice of auxiliary aids and services.
- Codifies application of appropriate auxiliary aids and services, including sign language interpreters, to entities with fewer than 15 employees.
- An individual providing qualified interpretation for an individual with a disability, e.g. sign language interpreter, must be qualified.
- Covered entities must ensure newly constructed and altered facilities are physically accessible to individuals with disabilities.
- The regulation includes a safe harbor for construction that was done in compliance with standards applicable at the time.
- Covered entities must make all health programs and activities provided through electronic and information technology accessible to individuals with disabilities.
- Covered entities must ensure non-discrimination in marketing and benefit design of health plans (which includes drug-tiering).

Who must comply with section 1557?
All health programs and activities that receive Federal financial assistance from HHS, which includes Iowa Medicaid providers, must comply with ACA Section 1557.

Health program or activity is broadly defined in the regulation and includes:
- The provision or administration of health related services, including behavioral health services

- State agencies, including Medicaid, Children's Health Insurance Program (CHIP), Basic Health Programs
- Medicare programs
- Hospitals
- Nursing facilities, intermediate care facilities for persons with intellectual/developmental disabilities, community residential facilities
- Health-related insurance
- Wellness programs
- Health research and education programs
- Includes all of the operations of an entity principally engaged in health services or health coverage.

When do these requirements go into effect?
The requirements of ACA Section 1557 are effective July 18, 2016.

OCR has indicated they intend to provide covered entities some flexibility to implement the requirements in the manner that they determine meets the standards of this section while also reducing burden.

This guidance is being issued by the IME to assist providers and covered entities with coming into compliance. This letter is not exhaustive and the IME strongly encourages providers and covered entities to review the ACA Section 1557 requirements in full, which can be found here[1], along with other useful resources and training materials.

If you have any questions, please contact the IME Provider Services Unit at 1-800-338-7909 or email imeproviderservices@dhs.state.ia.us.

[1] http://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html